FORM FOR REPORTING

MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #: _____

Date of Issuance: _____

Signature: _____

Name and Title (Please Type): _____

Date: _____

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